E-Verify

SENSITIVE BUT UNCLASSIFIED

Case Verification Number: 2017241142717QX

Report Prepared: 08/29/2017

Company Information

Company ID: 47429

Company Name: Employer Solutions Staffing Group

Employee Information

Last Name: hart

First Name: rayvon

Date of Birth: 03/13/1987

Social Security Number: *** ** 1062

Hire Date: 08/29/2017

Citizenship Status: A citizen of the United States

Document Information

List B Document: Driver's license or ID card issued by a U.S. state or outlying possession

List C Document: Social Security Card

Document Name: ID card

Document State: Minnesota

Driver's License or ID Card Number:

Document Expiration Date: 03/13/2021

Case Status Information

Current Case Result: Employment Authorized

Employer Case ID:

Case Submitted On: 08/29/2017

Case Submitted By: SGLA6832

SENSITIVE BUT UNCLASSIFIED

CORPORATE MANAGEMENT GROUP

Employment Application

Office Hours: 9am-4pm Mon-Fri
Office Number: 651-666-3883
Office Address: 404 Broadway Ave St. Paul Park, MN 55071

Applicant Information

(APPLICANTS MAY BE TESTED FOR ILLEGAL DRUGS AND A BACKGROUND CHECK WILL BE COMPLETED)

Please fully complete pages 1-3

Full Name: *(Last Name, First Name)* Hart Rayvan **Date:** 8/29/17

Address: *(Street Address)* 6700 W 86th Shakopee Rd *(Apt. /Unit #)* 329

(City) Bloomington *(State)* MN *(ZIP Code)* 55438

Phone: 612.990.5947 **Email:** rayvanhart87@gmail.com

Social Security No. 330-78-1062 **Date Available:** ASAP

Position Applied for: Production **Desired Salary:** 16.00$

Shift Available to work: ✓ 1st __ 2nd __ 3rd **Employment desired:** ✓ Full-Time __ Part-Time

What is your means of transportation to work? Automobile

Are you authorized to work in the U.S? ✓ Yes __ No

How did you hear about us? Career builder **Referral Name:** _____

If under 18, please list age: _____

Education

Type of School	Name of School	Location (Complete Mailing Address)	Number of Years Completed	Major & Degree
High School	Hubbs Center	800 University Ave	1	GED
College	Saint Paul college		1	Certification
Bus. Or Trade School				
Professional School				

Form W-4 (2017)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2017 expires February 15, 2018. See Pub. 505, Tax Withholding and Estimated Tax.

Note: If another person can claim you as a dependent on his or her tax return, you can't claim exemption from withholding if your total income exceeds $1,050 and includes more than $350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions don't apply to supplemental wages greater than $1,000,000.

Basic instructions. If you aren't exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

Nonresident alien. If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2017. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at *www.irs.gov/w4*.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	A	
B	Enter "1" if: • You're single and have only one job; or • You're married, have only one job, and your spouse doesn't work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	B	
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C	
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	D	
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above)	E	
F	Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit (**Note:** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	F	
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $70,000 ($100,000 if married), enter "2" for each eligible child; then **less** "1" if you have two to four eligible children or **less** "2" if you have five or more eligible children. • If your total income will be between $70,000 and $84,000 ($100,000 and $119,000 if married), enter "1" for each eligible child.	G	
H	Add lines A through G and enter total here. (**Note:** This may be different from the number of exemptions you claim on your tax return.) ▶	H	

For accuracy, complete all worksheets that apply.

- If you plan to **itemize or claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $50,000 ($20,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

---------- **Separate here and give Form W-4 to your employer. Keep the top part for your records.** ----------

Form **W-4** — Department of the Treasury, Internal Revenue Service

Employee's Withholding Allowance Certificate

▶ **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2017

1 Your first name and middle initial: Rayven	Last name: Hart	2 Your social security number: 330-78-1062
Home address (number and street or rural route): 6700 W Old Shakopee Rd	3 ☑ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note:** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
City or town, state, and ZIP code: Bloomington, MN, 55438	4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ▶ ☐	

5	Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)	5	
6	Additional amount, if any, you want withheld from each paycheck	6	$
7	I claim exemption from withholding for 2017, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here ▶	7	Exempt

Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.

Employee's signature (This form is not valid unless you sign it.) ▶ Rayven Hart **Date** ▶ 08/29/17

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	9 Office code (optional)	10 Employer identification number (EIN)	

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

▶START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the first day of employment, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*
Hart	Rayven	L	

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code
6700 W Old Shakopee Rd	329	Bloomington	MN	55438

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
03/13/1987	330-78-1062	ravenhart87@gmail.com	612.470.5447

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

- [x] 1. A citizen of the United States
- [ ] 2. A noncitizen national of the United States *(See instructions)*
- [ ] 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____
- [ ] 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
  Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____
   OR
2. Form I-94 Admission Number: _____
   OR
3. Foreign Passport Number: _____
   Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*
Rayven Hart	08/24/2017

Preparer and/or Translator Certification (check one):

- [x] I did not use a preparer or translator.
- [ ] A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP **Employer Completes Next Page** STOP

Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

Section 2. Employer or Authorized Representative Review and Verification
(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR one document from List B and one from List C, as listed on the reverse of this form.)

Employee Info from Section 1	Last Name (Family Name)	First Name (Given Name)	M.I.	Citizenship/Immigration Status
	Hart	Kayvon	J	4

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title MN DL		Document Title SSC
Issuing Authority		Issuing Authority State of MN		Issuing Authority SSA
Document Number		Document Number H738031980 18		Document Number 330-78-1062
Expiration Date (if any)(mm/dd/yyyy)		Expiration Date (if any)(mm/dd/yyyy) 03-13-2021		Expiration Date (if any)(mm/dd/yyyy)
Document Title				
Issuing Authority				
Document Number				
Expiration Date (if any)(mm/dd/yyyy)				
Document Title				
Issuing Authority				
Document Number				
Expiration Date (if any)(mm/dd/yyyy)				

Additional Information

QR Code - Section 2
Do Not Write In This Space

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment (mm/dd/yyyy): 08-29-2017 **(See instructions for exemptions)**

Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)	Title of Employer or Authorized Representative
Shelby Glasby	0829-2017	Recruiter

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name
Glasby	Shelby	Employer Solution Staffing Gro

Employer's Business or Organization Address (Street Number and Name)	City or Town	State	ZIP Code
7480 Flying Cloud Drive Suite 200	Eden Prairie	MN	55344

Section 3. Reverification and Rehires (To be completed and signed by employer or authorized representative.)

A. New Name (if applicable)

Last Name (Family Name)	First Name (Given Name)	Middle Initial	Date (mm/dd/yyyy)

B. Date of Rehire (if applicable)

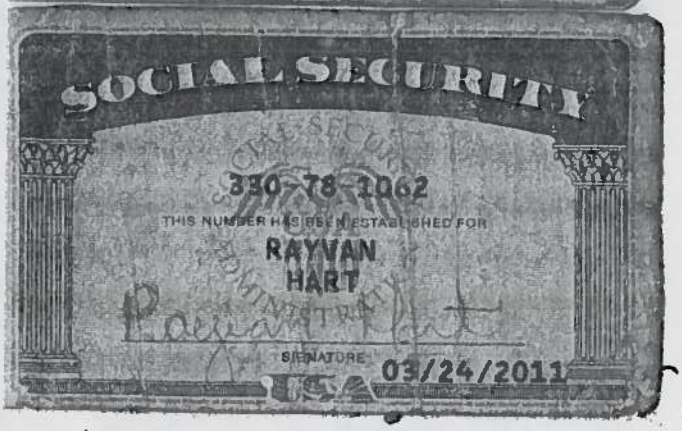
C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

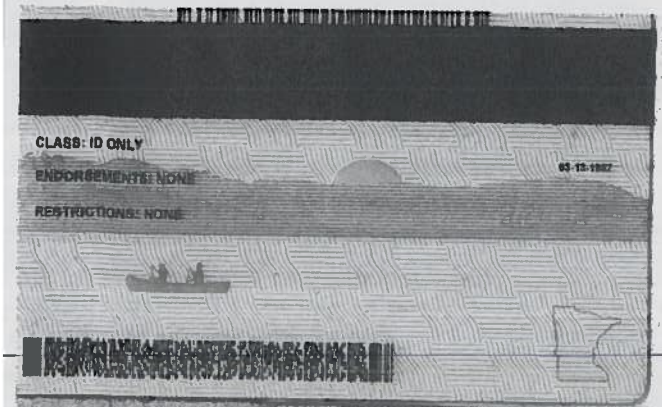
Document Title	Document Number	Expiration Date (if any) (mm/dd/yyyy)

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)	Name of Employer or Authorized Representative


MINNESOTA
IDENTIFICATION CARD
NOT A DRIVER'S LICENSE
RAYVON LAMONT HART JR
6700 W OLD SHAKOPEE RD #329
BLOOMINGTON, MN 55438
Date of Birth 03-13-1997
Sex M
Eyes BRN
Class ID
Height 5-9
Weight 160
ISSUED 04-2017
EXPIRES 03-13-2021
H738031938018


SOCIAL SECURITY
330-78-1062
THIS NUMBER HAS BEEN ESTABLISHED FOR
RAYVAN
HART
SIGNATURE
03/24/2011



This card belongs to the Social Security Administration and you must return it if we ask for it.

If you find a card that isn't yours, please return it to:
Social Security Administration
P.O. Box 33008, Baltimore, MD 21290-3008

For any other Social Security business/information, contact your local Social Security office. If you write to the above address for any business other than returning a found card you will not receive a response.

Social Security Administration
Form SSA-3000 (10-2007)

F85095631

EMERGENCY CONTACT INFORMATION

EMPLOYER SOLUTIONS STAFFING GROUP
IN CASE OF AN EMERGENCY - NOTIFICATION INFORMATION

Employee Name: Rayvan Hart
Address: 6700 J W Old Shakopee Rd
Home Phone: 612.990.5947

EMERGENCY CONTACTS Please list two people (in priority order) who could be contacted in case of an emergency	
Contact #1 Name: Kennesha Parker Relationship: Girlfriend	Home Phone: 651.285.7252 Cell Phone: Work Phone:
Contact #2 Name: Raven Roberson Relationship: Sister	Home Phone: 708.271.7703 Cell Phone: Work Phone:

Additional information you want Employer Solutions Staffing Group and our clients to know in the event of an emergency:

This information will remain confidential and will only be used in the case of an emergency.

employer solutions staffing group LLC
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Wage Payment Method Authorization (Minnesota)

Employees have the option of receiving wages by Direct Deposit and/or Payroll Debit Card.
If you do not provide a written election, wages will be paid by paper Check.

SECTION 1 BASIC INFORMATION

Employee Name	SSN# (last 4 digits)	Effective Date
Ravan Hart	1062	08/21/17

SECTION 2 PAYROLL ELECTION

☑ **Direct Deposit** (Please complete Sections 3 and 5 below) *Note: Direct Deposit accounts may take up to 7 days to be activated*
☐ **Payroll Debit Card** (Please complete Sections 4 and 5 below) ☐ **Paper Check** (Please complete Section 5 below)

SECTION 3 DIRECT DEPOSIT

ACCOUNT

☐ Update Bank Account
Bank Name: Meta Bank
Routing# 073972181
Account# 7000851751636 1
Account Type: ☑ Checking ☐ Savings ☐ Other _____

I understand and acknowledge that if I do not provide a voided check with this direct deposit form, I am responsible for any delays in payroll or extra costs incurred if the account number that I provide is incorrect.

Initial RH Date 08/29/17

- To help us avoid making an error, please attach a copy of a voided check. (a deposit slip will not work)
- If you change banks, do not close your old bank account until your direct deposit has started at the new bank, which may take 2 pay periods.

SECTION 4 PAYROLL DEBIT CARD (GLOBAL CASH CARD)

Federal law requires all financial institutions to obtain, verify, and record information that identifies each person who opens an account. In order to request a Payroll Debit Card for you, we must provide all of the following information that will enable the financial institution to identify you. If you do not submit a Direct Deposit/Payroll Debit Card Authorization, ESSG will provide the necessary information and issue you a Payroll Debit Card to pay your wages. For your protection, the financial institution may ask you to provide them additional identification information so they can verify your identity.

Except for the routing and account number, ESSG does not have access to any information regarding your Payroll Debit Card account or transactions. On your first payday, you will receive your new Payroll Debit Card, and a packet containing all of the terms and conditions. You will then sign acknowledging that you received the Payroll Debit Card and packet. Your Payroll Debit Card will be reloaded on each payday you receive wages.

CARDHOLDER INFORMATION (as you want your Payroll Debit Card to be issued)

First Name	M.I.	Last Name	Date of Birth

Street Address (PO BOX NOT ACCEPTABLE)	Social Security#

City	State	Zip	Cell Phone (mobile)

RECEIPT OF PAYROLL DEBIT CARD (to be completed when you pick up your Payroll Debit Card)

Payroll Debit Card Routing #	Payroll Debit Card Account #
073972181	

I have received my Payroll Debit Card, welcome brochure, program fees, program terms, conditions, and disclosures. By activating my Payroll Debit Card, I am agreeing to the program terms, conditions, and disclosures that are included or made available to me from time to time from the financial institution. I authorize the financial institution to debit my Payroll Debit Card account for the fees described in the fee schedule that is part of the program terms, conditions, and disclosures.

Employee's Signature: Ravan Hart Date: 08/29/17

SECTION 5 AUTHORIZATION

I authorize ESSG to directly deposit my periodic wages/compensation payments, net of required tax withholdings, other required withholdings or authorized deductions, into my account(s) as designated above and to initiate, if necessary, debit entries and adjustmentsfor any credit entries made in error to my account(s). *** E-mail is required for pay stub information.**

*E-mail: ravanhart87 @ gmail.com
this information will only be used to send your paystubs electronically

Employee's Signature: Ravan Hart Date: 08/29/17

Enroll in FREE[1] Direct Deposit Today

Have $500 or more direct-deposited to your ACE Elite Prepaid card during just one calendar month and you're automatically eligible for

Unlimited Purchase Transactions For just $5/month[2]

Get paid up to 2 days faster[3]

We'll spot you up to $10-with no added fee[4]

[1]There is no fee for direct deposit; however, transaction fees and other costs, terms and conditions are associated with the use of this card. Use of this card subject to funds availability. See the Cardholder Agreement ("Agreement") for details.

[2]The monthly cost for the FeeAdvantage Plan does not include ATM fees or any other fees described in the Agreement. Enrollment in this plan is optional; if you prefer, you may instead pay individual purchase transaction fees.

[3]Faster access to funds is based on comparison of traditional banking policies versus electronic direct deposit.

[4]This benefit is not an extension of credit; it is a non-contractual courtesy. Approved purchase transactions may create up to $10 negative balance on the card. Cardholder is responsible for repayment of any negative balances. See Agreement for details.

% % % % %

To Enroll in Direct Deposit:

If your employer or payor has its own direct deposit enrollment form, complete your employer's form and provide the bottom portion of this page in place of a voided check.

If your employer or payor does NOT have its own direct deposit enrollment form, read and complete the form below. Be sure to specify the "Effective" date, specify the "Amount", sign and date, then provide the completed form to your employer.

I wish to have all or part of my paycheck directly deposited to the account identified below. I authorize you (my employer or payor) to initiate electronic entries and if necessary, debit entries and adjustments for any credit entries made in error to my account each pay period. This authority will remain in effect until I notify my payor in writing or as otherwise specified by my payor.

Signature: _____ Date: _____

Employee Information:
RAYVAN HART JR
1623 CHARLES AVE 7
ST PAUL, MN 55104

Bank Information:
Account Type: ☑ Checking

Deposit Information:
Effective: ☐ As soon as possible (allow at least 2 pay periods)
☐ Beginning on: _____
Amount: ☐ Entire paycheck
☐ ____% of my paycheck
☐ Set amount: $_____

%(Cut here if submitting with employer form and attach)

meta®
5501 S. Broadband Ln.
Sioux Falls, SD 57108

This is not a check.

RAYVAN HART JR
1623 CHARLES AVE 7
ST PAUL, MN 55104

Date: "VOID""VOID""VOID"

Pay to the order of: "VOID" "VOID" "VOID" "VOID" "VOID" "VOID"
"VOID" "VOID" "VOID" "VOID" "VOID" "VOID" "VOID" "VOID"

$"VOID" "VOID"
dollars

"VOID" "VOID" "VOID" "VOID"

073972181 70003517516361
Routing Number Account Number

We do not accept deposits via wire transfers. We do not accept printed checks. Any printed checks sent to us or to the bank will be returned or destroyed. Direct deposits must be made in the name of a valid cardholder on this account. If you wish to receive direct deposit to this account from the employer of another member of your household, you must add a card to this account in the name of that household member.

Authorization

Authorization: By signing below, you authorize: (a) backgroundchecks.com ("BGC") and/or Orange Tree Employment Screening to request information about you from any public or private information source; (b) anyone to provide information about you to BGC and/or Orange Tree Employment Screening; (c) BGC and/or Orange Tree Employment Screening to provide Employer Solutions Staffing Group, LLC one or more reports based on that information; and (d) Employer Solutions Staffing Group, LLC ("ESSG") to share those reports with others for legitimate business purposes related to your employment. BGC and/or Orange Tree Employment Screening may investigate your education, work history, professional licenses and credentials, references, address history, social security number validity, right to work, criminal record, lawsuits, driving record, credit history, and any other information with public or private information sources. You acknowledge that a fax, image, or copy of this authorization is as valid as the original. You make this authorization to be valid for as long as you are an employee of ESSG.

The Consumer Financial Protection Bureau's "Summary of Your Rights under the Fair Credit Reporting Act" is attached to this authorization. If you are a New York applicant, a copy of New York's law on the use of criminal records is attached. By signing below, you acknowledge receipt of these documents.

Personal Information: Please print the information requested below to identify yourself for BGC.

Printed name: Rayvon (First) | (Middle (☐ none)) | Hart (Last)

Other names used:

Current county of residence:

Current and former addresses:

from Mo/Yr	to Mo/Yr	Street	City, State & Zip
08/2016	current	6700 W Old Shakopee Rd	Bloomington, MN, 55438
10/2014	08/2016	1623 Charles Ave	St. Paul, MN, 55104
10/2011	08/2013	1757 Thomas Ave	St. Paul, MN, 55104

Some government agencies and other information sources require the following information when checking for records. BGC will not use it for any other purposes.

03/13/84 (Date of birth)	360-78-1062 (Social security number)
H738031935018 (Driver's license number & state)	Rayvon Lamont Hart Sr. (Name as it appears on license)

Report Copy: If you are applying for a job or live in California, Minnesota, or Oklahoma, you may request a copy of the report by checking this box: ☐.

Rayvon Hart — Signature

08/29/17 — Date

Preliminary Questions
For CMG use only

Name: Rayvan Hart

Date: 08/29/17

1. If hired are you willing to take a drug test? yes
2. Do you have any known food allergies to soy, wheat, peanuts, or milk? no
3. Are you able to work with pork? yes

To be completed during or after interview

Have you ever been convicted, plead guilty or contest to a Felony? Yes_____ No ✓

If yes, please list when, where and the nature of the offense(s):

Have you ever been convicted, plead guilty or contest to a Misdemeanor? Yes_____ No ✓

If yes, please list when, where and the nature of the offense(s):

You will not be denied employment solely because you answer "Yes" above or because you have been convicted of a crime, felony or misdemeanor. The company considers many individualized factors in evaluating a job candidate, including but not limited to, with respect to criminal history, the nature and date of any offense, the surrounding circumstances, and the nature of the position for which you apply.

By signature below, I certify that the information provided above is true and complete that I have discussed the above with my interviewer as disclosed. I understand and agree that any misrepresentation by me will be sufficient cause to eliminate me from consideration for employment and/or terminate employment at any time if I have been employed.

Applicant signature: Rayvan Hart Date: 08/29/17

employer solutions staffing group LLC

Leveraging Resources in a Changing Market

STATEMENT OF CONFIDENTIALITY

This agreement made this 31 day of August, 2011, between Employer Solutions Staffing Group LLC, hereinafter referred to as "employer", and Rayven Hart hereafter referred to as "employee".

WITNESSETH:

For the duration of my employment and after resignation or termination of this employment with employer, for any reason whatsoever, the employee shall not use or disclose to any other person or company, and confidential or proprietary information or know-how related to the business of the employer.

In view of the difficulty of determining the amount of damages which may result to the employer from a violation of any of the provisions hereof, the employee agrees to pay to the employer the sum of $10,000 as liquidated damages for every such violation; provided, however, that the payment of such amount as liquidated damages shall not be construed as a release or waiver by the employer of the right to prevent any such violation in equity or otherwise.

Rayven Hart

Employee Signature

Employer Solutions Staffing Group LLC, Representative

employer solutions staffing group
Leveraging Resources in a Changing Market

INJURY MANAGEMENT PROGRAM

Injured Worker's Responsibilities

As your employer, we are concerned about your full recovery. Reasonable and necessary medical care will be paid for any compensable work injury. Medically authorized time away from work will be reimbursed in accordance with the **State of Minnesota workers' compensation laws**. Wherever possible light duty restrictions imposed as a result of your injury will be accommodated.

RESPONSIBILITIES OF THE INJURED WORKER:

Minnesota Rule Sec. 5221.0430, Subp. 1 requires that you choose one primary health care provider. Subpart 2 places limitations on your right to change primary health care providers. Discuss with your employer any change in health care provider.

Attend all scheduled appointments. While on physical limitations, visits should be a minimum of once every two weeks. Failure to have current medical support for disability may result in termination of benefits. Schedule your next appointment immediately after your doctor visit, before you leave the clinic if possible.

Obtain a Report of Workability from your physician at every appointment, a minimum of once every two weeks. M.R. 5221.0420 requires that your physician cooperate with return to work planning and that you be released to return to work at the earliest appropriate time.

Immediately following your appointment, provide a copy of the report to the designated employer representative. You should deliver this in person so that changes in work restrictions may be addressed and any questions answered.

Follow all physical restrictions at home and at work.

Report to work and perform physically suitable tasks as assigned. These may or may not be in your regular department. The work may or may not be on your usual shift.

employer solutions staffing group LLC

Leveraging Resources in a Changing Market

Important/Importante

LOST OR STOLEN PAYCHECKS

If a paycheck is **lost** (*missing, misplaced, destroyed, lost in the mail, etc.*), you must notify your staffing recruiter that the check cannot be found. If it can be verified that the check has not been cashed, ESSG will stop payment on the check and re-issue the check to you, deducting a fee of between $25-$35.

If your paycheck was **stolen**, you must first file a police report before we can re-issue the check. Once you have done so, you must provide a copy of the policy report to your staffing recruiter that the check was stolen. If the check has not been cashed and if the loss of the check was not your fault, ESSG will issue a new check and no fee will be deducted.

CHEQUES DE PAGO PERDIDOS O ROBADOS

Si un cheque de pago se pierde (que falta, fuera de lugar, destruido, perdido en el correo, etc), usted debe notificar a su reclutador de personal que el cheque no se puede encontrar. Si se puede verificar que el cheque no ha sido cobrado, ESSG se detendrá el cheque de pago y reemitir el cheque a usted, descontando un cargo de entre $ 25 - $ 35.

Si su cheque de pago fue robado, primero debe denunciar el robo a la policía antes de que podamos volver a emitir el cheque. Una vez hecho esto, usted debe proporcionar una copia de la denuncia a su reclutador de personal que el cheque fue robado. Si el cheque no ha sido cobrado y si la pérdida del cheque no fue su culpa, ESSG emitirá un nuevo cheque y no hay cuota se deducirá.

AGREED/SE ACUERDA—

Name/Nombre (con letra de molde): Rayvan Hart

Signature/Firma: Rayvan Hart

Form **8850** (Rev. March 2016)
Department of the Treasury
Internal Revenue Service

Pre-Screening Notice and Certification Request for the Work Opportunity Credit

▶ Information about Form 8850 and its separate instructions is at *www.irs.gov/form8850.*

OMB No. 1545-1500

Job applicant: Fill in the lines below and check any boxes that apply. Complete only this side.

Your name Rayvon Hart Social security number ▶ 330-78-1062

Street address where you live 6700 W Old Shakopee Rd. #329

City or town, state, and ZIP code Bloomington MN, 55438

County Hennepin Telephone number 6124905947

If you are under age 40, enter your date of birth (month, day, year) 03/13/1987

1 ☐ Check here if you received a conditional certification from the state workforce agency (SWA) or a participating local agency for the work opportunity credit.

2 ☐ Check here if **any** of the following statements apply to you.
- I am a member of a family that has received assistance from Temporary Assistance for Needy Families (TANF) for any 9 months during the past 18 months.
- I am a veteran and a member of a family that received Supplemental Nutrition Assistance Program (SNAP) benefits (food stamps) for at least a 3-month period during the past 15 months.
- I was referred here by a rehabilitation agency approved by the state, an employment network under the Ticket to Work program, or the Department of Veterans Affairs.
- I am at least age 18 but **not** age 40 or older and I am a member of a family that:
  a. Received SNAP benefits (food stamps) for the past 6 months; **or**
  b. Received SNAP benefits (food stamps) for at least 3 of the past 5 months, **but** is no longer eligible to receive them.
- During the past year, I was convicted of a felony or released from prison for a felony.
- I received supplemental security income (SSI) benefits for any month ending during the past 60 days.
- I am a veteran and I was unemployed for a period or periods totaling at least 4 weeks but less than 6 months during the past year.

3 ☐ Check here if you are a veteran and you were unemployed for a period or periods totaling at least 6 months during the past year.

4 ☐ Check here if you are a veteran entitled to compensation for a service-connected disability and you were discharged or released from active duty in the U.S. Armed Forces during the past year.

5 ☐ Check here if you are a veteran entitled to compensation for a service-connected disability and you were unemployed for a period or periods totaling at least 6 months during the past year.

6 ☐ Check here if you are a member of a family that:
- Received TANF payments for at least the past 18 months; **or**
- Received TANF payments for any 18 months beginning after August 5, 1997, **and** the earliest 18-month period beginning after August 5, 1997, ended during the past 2 years; **or**
- Stopped being eligible for TANF payments during the past 2 years because federal or state law limited the maximum time those payments could be made.

7 ☐ Check here if you are in a period of unemployment that is at least 27 consecutive weeks and for all or part of that period you received unemployment compensation.

Signature—All Applicants Must Sign

Under penalties of perjury, I declare that I gave the above information to the employer on or before the day I was offered a job, and it is, to the best of my knowledge, true, correct, and complete.

Job applicant's signature ▶ Rayvon Hart Date 08/29/17

Form A (rev. 01/2016)

TAX CREDIT QUESTIONNAIRE

RETROTAX
Specialists in Tax Credit Administration

EMPLOYER SECTION:

Client: Employer Solutions Group	Company:	
Location:	Position:	Starting Wage: $

EMPLOYEE SECTION:

Employee Name: Rayton Hart	Street Address: 6700 W 0th Shakopee Rd	City/State: Bloomington, Mn	Zip: 55438

SS#: 330-78-1062	Date of Birth: 03/13/1987	Age: 30	Have you worked for this company before? ☐ Yes ☑ No	If yes, location:

Please complete all questions, and sign and date the form.

	Yes	No
1. Have you or has anyone living with you received Temporary Assistance to Needy Families (TANF) at any time since August 5, 1997? (If yes, please provide information below.) Name of the person receiving benefits: _____ Relationship to you: _____ City: _____ County: _____ State: _____	☐	☐
2. Have you or has anyone living with you received Food Stamps (SNAP) at any time during the past 15 months? (If yes, please provide information below.) Name of the person receiving benefits: _____ Relationship to you: _____ City: _____ County: _____ State: _____	☐	☐
3. Have you received Supplemental Security Income (SSI) at any time within the past 3 months? Please note, this is not the same as Social Security benefits (SS) or Social Security Disability (SSDI) benefits. **If you checked yes please provide a copy of your SSI documentation.*	☐	☐
4. Have you received any type of vocational rehabilitation services within the past two years? If yes, please indicate which type of agency you worked with and provide their location information below: ☐ Vocational Rehabilitation Agency ☐ Dept. of Veterans Affairs ☐ Employment Network (Ticket to Work Program) Name of Agency: _____ Phone #: _____ City: _____ County: _____ State: _____ **If you checked yes please provide a copy of your active Individual Work Plan and Ticket to Work documentation.*	☐	☐
5. Are you a Veteran of the U.S. Military? **If yes, please provide a copy of your DD-214 and letter of separation.* (If yes, please provide information below. If no, please continue to question #6.) Dates of Service - From: ___/___/___ To: ___/___/___ Branch of Service: _____ **Are you entitled to or are you receiving compensation for a service-connected disability?**	☐ ☐	☐ ☐
6. Have you been unemployed at any time during the last 12 months? If yes, dates of unemployment - From: ___/___/___ To: ___/___/___ **Did you receive unemployment compensation at any point during your unemployment?** If yes, dates received unemployment compensation - From: ___/___/___ To: ___/___/___	☐ ☐	☐ ☐
7. Have you been convicted of a felony or released from prison for a felony conviction in the past 12 months? Conviction Date: ___/___/___ Release Date: ___/___/___ Was this a ☐ Federal or ☐ State conviction? If State - County: _____ State: _____	☐	☐
Additional Tax Credits **IEC (Native American):** Are you or your spouse a member of a Native American Tribe? **If you checked yes please provide a copy of your CDIB card.* **CA Residents:** ☐ Are you the child of foster parents? ☐ Do you receive CalWorks? ☐ Workforce Investment Act? ☐ Are you a migrant or seasonal farm worker? ☐ Have you ever been convicted of a misdemeanor? **SC Residents:** ☐ Do you receive Family Independence Benefits?	☐	☐

PLEASE READ, SIGN, AND DATE:

Under penalties of perjury, I declare the information above to be true and accurate to the best of my knowledge, and I hereby authorize any agency, organization, or individuals to supply such verification or information that may be needed to determine tax credit eligibility to my employer, employer representative (Associated Consultants, Inc. dba Retrotax), or the Department of Labor.

New Employee Signature: Rayton Hart **Date:** 08/29/17

RETROTAX
Specialists in Tax Credit Administration

Qualified Long-Term Unemployment Recipient

ADDENDUM TO: IRS Form 8850 Pre-Screening Notice and Certification Request for the Work Opportunity Tax Credit

Client: Employer Solutions Group	Company:	
Location:	Employee Name: Rayna Hart	SS#: 330-78-1062

EMPLOYEE:

Please check the statement(s) that apply to you and sign where indicated below.

☐ I have been unemployed at any time during the last 12 months.

If applicable, dates of unemployment - From: ____/____/____ To: ____/____/____
From: ____/____/____ To: ____/____/____
From: ____/____/____ To: ____/____/____

☐ I received unemployment compensation during my unemployment.

If applicable, dates you received compensation - From: ____/____/____ To: ____/____/____
From: ____/____/____ To: ____/____/____
From: ____/____/____ To: ____/____/____

Please read, sign, and date:

Under penalties of perjury, I declare that this information is true and correct to the best of my knowledge.

Employee Signature: Rayna Hart	Date: 05/29/17

RetroTax®
3730 Washington Blvd.
Indianapolis, IN 46205
317-925-0553
wotc@retrotax-aci.com
www.retrotax-aci.com

employer solutions staffing group llc

Notification of Minnesota Law Requirement – Unemployment Acknowledgement

According to Minnesota Statute section 268.095, subdivision 2, paragraph (d), an applicant who, within five calendar days after completion of a suitable job assignment from a staffing service, (1) fails without good cause to affirmatively request an additional suitable job assignment, (2) refuses without good cause an additional suitable job assignment offered, or (3) accepts employment with the client of the staffing service, is considered to have quit employment.

It is your responsibility to contact ESSG (for instance, by calling 952.277.5227 or using any other form of contact) for additional assignments. If you fail to do so, it may affect your unemployment benefits.

I understand by signing this form that I am responsible to contact ESSG within 5 calendar days once an assignment ends. I also acknowledge that I have received a separate copy of this form. RH (Initial)

Rayvan Hart
Employee Signature:

08/29/17
Date:

Rayvan Hart
Employee (please print your name here)

DRUG AND ALCOHOL
TESTING CONSENT FORM

1. I have been allowed to read and inspect a written copy of ESSG policy on drugs and alcohol.

2. I have read the entire contents of this policy and I am aware and fully understand: (a) the policy and its contents; (b) what conduct the policy prohibits and the consequences of such conduct; (c) my rights under the policy and the consequences if I exercise certain rights; and (d) that certain events as described in the policy may result in adverse personnel action, including my termination from employment with ESSG. I understand that this policy in any form, and any employee handbook including this policy, are not a unilateral employment contract or offer thereof.

3. I hereby voluntarily consent to ESSG, or its health service providers, or other persons or entities acting for or with them, to collect a body component (blood, urine, breath, or any combination thereof) from me for testing for alcohol and/or drugs. I understand that the laboratory selected by ESSG may conduct testing and other analysis on the sample provided by me. I further voluntarily consent to the laboratory's disclosure to ESSG of the results of my drug and/or alcohol test and other information related to the test.

Rayvan Hart
Individual's Name

08/29/17
Date

SIGN THIS VERSION OF CONSENT—SAME AS PAGE 6

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Leveraging Resources in a Changing Market

ESG employer solutions group.

ESNG employer solutions nationwide group.

Benefit Plan Administrators, I

Enhanced MEC Plan_Plan 1

Benefits Enrollment Form ☐ New Employee ☐ Rehire Rehire Date_____

Employee Information

Name (First and Last)			Social Security Number
Ravan Hart			330-78-1062
Address	**City**	**State**	**Zip Code**
6700 W Old Shakopee Rd	Bloomington	MN	55438

Gender ☒ Male ☐ Female | **Marital Status** ☒ Single ☐ Married ☐ Divorced | **Date of Birth** 03/13/1987 | **Date of Hire** 08/24/17

Phone Number: 612-990-5947 | **Email Address:** ravanhart87@gmail.com

Please Select Desired Coverage:

☐ Employee Only - $24.00/Week ☐ Employee+Spouse - $38.00/Week ☐ Employee+Child(ren) - $36.00/Week ☐ Family - $63.00/Week

Dependent Information

First Name	M.I.	Last Name	Social Security #	Birth Date	Sex	Relationship
					☐ Male ☐ Female	☐ Spouse ☐ Child ☐ Domestic Partner
					☐ Male ☐ Female	☐ Spouse ☐ Child ☐ Domestic Partner
					☐ Male ☐ Female	☐ Spouse ☐ Child ☐ Domestic Partner

Other coverage information including Medicare/Medicaid

NAME OF PERSON COVERED (FIRST, LAST):

EFF. DATE

EFF. DATE

EFF. DATE

Employee Acknowledgement and Authorization - I hereby apply for the group benefit(s) as indicated. I acknowledge that all entries are true and complete and that any misstatements or failure to report information may be used as the basis for cancellation of coverage for me and my dependent(s), if any, from the original effective date. Further, I authorize my employer to make the necessary payroll deduction of premiums for coverages I have elected.

IF ENROLLING - YOU MUST SIGN HERE

Employee Signature _____ Date _____

EMPLOYEES DECLINING ☒ I am DECLINING coverage

I understand that I and/or my dependents, if any, waive any coverage and desire to participate in the plan at a later date. I/we may be considered a late enrollee and must meet the requirements defined in the Certificate of Coverage for the company's medical or dental plans. If I decline enrollment for myself or my dependents (including my spouse) because of other coverage, I may, in future be able to enroll myself or my dependents in this plan, provided I request enrollment within 31 days after the other coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption, placement for adoption of parting suit of adoption, I may be able to enroll myself or my dependent, provided I request enrollment within 31 days of the event.

IF DECLINING- YOU MUST SIGN HERE

Employee Signature Ravan Hart Date 08/24/17

Employer Solutions Staffing Group Health Benefits Team
7301 Ohms Lane Suite 405
Edina, MN 55439
Phone: 952-767-9519 Fax: 952-767-9515
Email: Health@employersolutionsgroup.com

VSI • 219301-ESG-1 | OFFICE USE ONLY | LOCATION _____ | Rehire Date __/__/____

ENROLLMENT FORM

ESC CU(UNAC-MN) P1 v1

A. REQUIRED EMPLOYEE INFORMATION

PRINT USING BLACK or BLUE INK (Must Be Filled Out)

Name Raylan Hart | Social Security # 330-78-1062 | Home Phone 612-990-5947 | Sex M F

Address 6700 W 101st Shakopee Rd. | Apt. # 329

City Bloomington | State MN | Zip 55435 | Date of Birth 03/31/84

B. DO YOU OR ANY OF YOUR DEPENDENTS RECEIVE MEDICARE BENEFITS?

☐ Yes ☐ No. If Yes, please continue.

Medicare Health Insurance Claim Number (HICN)

Medicare Effective Date

Name of Covered Person (s):
1. 2. 3.

C. LIMITED BENEFITS PLAN SELECTION

Payroll Deducted Weekly Rat

You **MUST** select a coverage level before any benefits in Section C. Your coverage level for the all benefits in Section C will b identical. The Fixed Indemnity Medical Plan, Dental Plan, Term Life Plan, and Short-Term Disability plans are underwritten by BC Insurance Company. The Vision plan is underwritten by Companion Life Insurance Company.

SELECT COVERAGE LEVEL	FIXED INDEMNITY MEDICAL [1]	DENTAL	VISION	TERM LIFE	SHORT-TERM DISABILITY [2]
Employee Only ☐	$20.25	$6.17	$2.42	$0.60	$4.20
Employee + 1 ☐	$41.10	$12.34	$4.92	$0.90	
Employee + Family ☐	$54.88	$20.36	$6.56	$1.80	
NO to ALL Benefits ☑	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ N

[1] This coverage is not available to residents of NH, HI, or PR. [2] STD is not available to persons who work in CA, HI, NJ, NY, or RI.

For Term Life / Accidental Death & Dismemberment, please write in your beneficiary information. Accidental Death & Dismemberment is part of the Term Life Benefit.

Name _____ Relationship _____

D. REQUIRED DEPENDENT INFORMATION

Name	Social Security #	Date of Birth	Sex	Relationship
		/ /	M F	☐ Spouse ☐ Child ☐ Domestic Partne
		/ /	M F	☐ Spouse ☐ Child ☐ Domestic Partne
		/ /	M F	☐ Spouse ☐ Child ☐ Domestic Partne
		/ /	M F	☐ Spouse ☐ Child ☐ Domestic Partne

E. REQUIRED SIGNATURE

YOU MUST SIGN AND DATE, EVEN IF YOU DECLINE COVERAGE

I have read the benefit packet and understand its limitations. I understand that open enrollment is only available for a limited time and I understand that making no benefit selection is a declination of coverage.

DATE 06/29/2017 ▶ **SIGNATURE** Raylan Hart